**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name**
AZAR MARAGHI, D.C.

**Respondent Name**
SAFETY NATIONAL CASUALTY CORP

**MFDR Tracking Number**
M4-14-1150-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
DECEMBER 5, 2013

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "After reviewing our claims, we were under paid for dates noted above for service codes **97545 WH and 97546 WH**."

**Amount in Dispute:** $8,164.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** The respondent did not submit a response to this request for medical fee dispute resolution.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| January 30, 2013<br>February 4, 2013<br>February 8, 2013<br>February 20, 2013<br>March 4, 2013<br>March 11, 2013<br>March 18, 2013<br>March 20, 2013<br>March 27, 2013<br>April 1, 2013 | CPT Code 97545-WH (2 hours)<br>Work Hardening | $207.60 X 10<br>= $2,076.00 | $1,536.00 |
| January 30, 2013<br>February 4, 2013 | CPT Code 97546-WH (4 hours)<br>Work Hardening | $455.20 X 2 =<br>$910.40 | |
| February 8, 2013<br>February 20, 2013<br>March 4, 2013<br>March 11, 2013<br>March 18, 2013<br>March 20, 2013<br>March 27, 2013<br>April 1, 2013 | CPT Code 97546-WH (4 hours)<br>Work Hardening | $647.20 X 8 =<br>$5,177.60 | |
| TOTAL | | $8,164.00 | $1,536.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed services.
3. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on December 27, 2013. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1-Workers compensation state fee schedule adjustment.
   - 309-The charge for this procedure exceeds the fee schedule allowance.
   - OA-The amount adjusted is due to bundling or unbundling of services.

**Issues**

Is the requestor entitled to additional reimbursement for the work hardening program rendered from January 30, 2013 through April 1, 2013?

**Findings**

The respondent paid $1,536.00 for the work hardening program based upon reason codes "W1 and 309."

The requestor states that "we were under paid for dates noted above for service codes 97545 **WH and 97546 WH**."

The issue in dispute is whether the payment was in accordance with the Division fee guideline, and if additional reimbursement is due.

28 Texas Administrative Code §134.204(h)(1)(B) states "If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

28 Texas Administrative Code §134.204(h)(3)(A) and (B) states "For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.

(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes."

The Division finds that the requestor billed CPT code 97545WH and 97546WH for sixty units. Therefore, per 28 Texas Administrative Code §134.204(h)(1)(B) and (3)(A) and (B), the MAR for a non-CARF accredited program is $51.20 per hour ($64.00 X 80%). $51.20 times the 60 hours billed is $3,072.00. The respondent paid $1,536.00. The difference between the MAR and amount paid is $1,536.00. This amount is recommended for additional reimbursement.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,536.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,536.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | 07/03/2014<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.